Thank you for choosing North Carolina Solutions are your Applied Behavior Analysis provider! It is our goal to help you and your family achieve the results that last a lifetime through high quality services. To ensure the client is receiving the appropriate level of care, a well-trained, Board Certified Behavior Analyst, develops a comprehensive treatment plan. This plan helps build skill level and decrease barriers to learning. Caretakers must comply with all treatment recommendations pertaining to the clients plan to continue to receive services at North Carolina Solutions. This includes keeping all of your appointments as they are scheduled. If recommendations are not followed, you may be referred to another provider. Legal caretakers have the right to access the client's treatment plan upon request.

Please provide the front desk with up to date phone number that allows us to leave a message regarding your appointments if needed.

Thank you again for choosing North Carolina Solutions! Do not hesitate to let us know how we are doing.

Thank you

Han-Leong Goh, Ph.D, BCBA-D
Executive Director

3904 Oleander Dr #102 Wilmington, NC 28403 | 910-313-3232

Biographical

Child's Name:______________________________ Date of Birth:____________________

Caregiver/Legal Guardian #1

Name:__________________________________

Address:________________________________

City, State, Zip:_____________________________

Telephone:_________________(Home) __________________(Work)

_________________(Cell)

Email:________________________________

Emergency Contact

Name:___________________________

Phone:___________________________

Current Medical Providers and School Information

Name of Primary Care Physician:______________________________

Affiliation:____

Name of Teacher:____

School:____

Referral Source

Affiliation:____

Sign/Date

_________________________________ _____________________

Signature of Client/Parent/Legal Guardian Date

_________________________________ _____________________

Signature of NC Solutions Staff Date

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PRIOR PROFESSIONAL CONTACTS

Please list all past and current therapies your child has received by completing each of the boxes below.

Service	Start/End Date (Month/ Year)	How Often?	Length of each therapy session	What goals were being addressed?	Effect of therapy for feeding problem	Therapist Information (Name, address, telephone)
Occupational Therapy ☐ Yes ☐ No		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ ______	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1 5 hrs ☐ ______		☐ Worse ☐ No change ☐ Improved	
Physical Therapy ☐ Yes ☐ No		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ ______	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ ______		☐ Worse ☐ No change ☐ Improved	
Speech ☐ Yes ☐ No		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ ______	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ ______		☐ Worse ☐ No change ☐ Improved	
Early Intervention ☐ Yes ☐ No		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ ______	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ ______		☐ Worse ☐ No change ☐ Improved	
Others: (please list)		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ ______	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ ______		☐ Worse ☐ No change ☐ Improved	

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MEDICAL INFORMATION

Birth History

How many weeks pregnant were you when your child was born? ____________

Was your child born by vaginal delivery or C-section? ____________

What was your child's birth weight/length? ____________ lbs ____________ inches

Were there any problems at birth? ____________

Were there any problems during pregnancy? ____________

Medical History

Current Diagnoses: ____________

At what age did your child receive each diagnosis: ____________

Who provided the diagnosis: ____________

Previous Illnesses: ____________

Most recent hearing screen: ____________; Results: ____________

Most recent vision screen: ____________; Results: ____________

Past surgeries/hospitalizations: ____________

History of any of the following? (Check all that apply):

☐ Seizures ☐ Diabetes ☐ Asthma ☐ Constipation (frequent)
☐ Vision problems ☐ Hearing Problems ☐ Sleep Problems

Describe all checked items above:

____

____

Current medications and dosages:

____

____

Allergies: Medications/Environmental/Seasonal: ____________

Food Allergies: ____________

Food Intolerance? (e.g. lactose intolerance): ____________

Are immunizations up-to-date: ____________

If not up-to-date, what is delinquent? ____________

Any foods avoided intentionally by the family? ____________

Does your child have any health-related restrictions regarding exercise?

Current height: ____ feet, ____ inches

Current weight: ______ lbs

At what age did your child:

DEVELOPMENTAL HISTORY

Roll over: ____________

Sit independently: ____________

Take first steps: ____________

Play games (like peek-a-boo): ____________

Crawl: ____________

Smile: ____________

Babble: ____________

Use single words: ____________

Use short phrases: ____________

Use sentences: ____________

Toilet trained during day: ____________

Toilet trained at night: ____________

As an infant/toddler, was your child:

- ☐ Interested in people
- ☐ Overly active
- ☐ Easy to please
- ☐ Irritable/Cranky
- ☐ Difficult to nurse or feed
- ☐ Interested in toys
- ☐ Underactive
- ☐ Able to be flexible
- ☐ Difficult to soothe
- ☐ Resistant to touch
- ☐ Reactive to certain noises

SLEEP SCHEDULE

Check any that describe your child.

- ☐ Has difficulty going to sleep at night
- ☐ Tantrums when put to bed
- ☐ Has other behavior problems when put to bed
- ☐ Has difficulties going to sleep during naps
- ☐ Has difficulties staying asleep
- ☐ Has difficulties staying in bed
- ☐ Wants to sleep in caregiver's bed

My child goes to bed at ____________________ pm.
My child wakes up at ______________________ am.
My child takes a nap from _____________ to ____________ and _____________ to ___________.

COMMUNICATION

What is your child's primary form of communication?

☐ Gestures ☐ Picture Exchange ☐ Sign Language ☐ Vocal Language ☐ Other_________

How does your child request items?

____

____

Does your child... (Select Yes or No)
Respond to his/her name?
Imitate words/sounds you say? Example____________________________________
Imitate words/sounds from his/her favorite videos? Example________________________
Label things that he/she sees? Example____________________________________
Label things that he/she feels? Example____________________________________
Label things that he/she smells? Example____________________________________
Label things that he/she hears? Example____________________________________
About how many different things can your child label? ____________________________________

Does your child... (Select Yes or No)
Follow one step directions? Example____________________________________
Follow two or more step directions? Example____________________________________

Respond to questions? Example____________________________________
About how many questions can your child respond? ______________________________________
Tell you what happened during the day? Example_______________________________
How many different words does your child say in a 30-minute period? __________

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ADAPTIVE SKILLS

Check one that best describes your child's mental abilities.

☐ Normal Intelligence ☐ Mild ID ☐ Moderate ID

☐ Severe ID ☐ Profound Intellectual Disability (ID)

Does your child... (Select Yes or No)

Feed self
Dress self
Help with household chores
Tie shoes
Walk up/down stairs
Stay near in public places
Imitate things you do
Talk to peers

Look you in the eye when you are talking
Makes eye contact when pointing
Point to things from 3 feet away or more
Play with toys the same way
Play with a limited number of toys
Play with toys appropriate (hit nails with hammer)
Play with toys imaginatively (use box as phone)
Plays with toys next to others

OTHER BEHAVIOR PROBLEMS

Does your child have any other behaviors that you think are a problem? Check any one that describes your child's behavior.

Behavior	Occurs	Frequency
Temper tantrums	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Argues	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Hurts self	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Hurts other people	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Complains of aches or pains	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Throws or breaks things	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Makes inappropriate sounds	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Attention Deficits	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Phobias	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Overactive for age	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Separation anxiety	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Doesn't pay attention	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Stereotypy (hand-flapping)	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Arm/Hand biting	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Thumb sucking	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Doesn't interact with people	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Masturbation	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Pica (eats inedible objects)	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Insists on routine	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Other______	☐	____ times per ☐ hour ☐ day ☐ week ☐ month

What type of supervision does your child require? (Check one)

☐ Can be left unattended for brief periods of time
☐ Needs continuous monitoring, but can be accomplished in a group
☐ Requires 1:1 supervision

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OTHER INFORMATION

If your child had an hour to do whatever he/she wanted. Please list which toys, activities, foods, or people he/she would play with:

Toys

1)
2)______________________
3)______________________
4)______________________
5)______________________
6)______________________
7)______________________
8)______________________
9)______________________

Foods

1)______________________
2)______________________
3)______________________
4)______________________
5)______________________
6)______________________
7)______________________
8)______________________
9)______________________

Activities

1)______________________
2)______________________
3)______________________
4)______________________
5)______________________
6)______________________
7)______________________
8)______________________
9)______________________

People

1)______________________
2)______________________
3)______________________
4)______________________
5)______________________
6)______________________
7)______________________
8)______________________
9)______________________

What are your top 3 goals for your child in the next 6 months, rank the priority of the goal, and describe what specifically needs to be addressed.

Priority:

1= not important, 2= somewhat not important, 3= Neutral, 4= somewhat important, 5= very important

Rank (1-3)	Skill	Priority	Describe
	Communication		
	Play Skills		
	Social Skills		
	Problem Behavior		
	Functional Skills (toileting)		
	Other:____________		

3904 Oleander Dr. #102 Wilmington, NC 28403 | 910-313-3232

Child Availability

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am	☐	☐	☐	☐	☐
9:00 am	☐	☐	☐	☐	☐
10:00 am	☐	☐	☐	☐	☐
11:00 am	☐	☐	☐	☐	☐
12:00 pm	☐	☐	☐	☐	☐
1:00 pm	☐	☐	☐	☐	☐
2:00 pm	☐	☐	☐	☐	☐
3:00 pm	☐	☐	☐	☐	☐
4:00 pm	☐	☐	☐	☐	☐
5:00 pm	☐	☐	☐	☐	☐

Please indicate how interested you are in learning methods to teach your child new skills.

Not at all Interested	Somewhat Interested	Interested	Very Interested	Extremely Interested
☐	☐	☐	☐	☐

Please indicate how many hours each day you and your child are in the same room.

0-2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours	More than 8 hours
☐	☐	☐	☐	☐

Please indicate how many hours each day you practice new skills with your child.

0-2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours	More than 8 hours
☐	☐	☐	☐	☐

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

Client Name: ______________________________ **Date of Birth:** ____________________

FROM (PERSON/AGENCY): *NC SOLUTIONS*

TO (PERSON/AGENCY) Emergency Contact

FROM (PERSON/AGENCY) Emergency Contact

TO (PERSON/AGENCY) *NC SOLUTIONS*

INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):

___Admission/ Evaluation /CCA ___Medications ___Medical/Physical History
___Discharge Summary ___Labs ___History/Psychosocial
___Staff Notes ___Treatment Progress ___Testing
___Other: ____

RELEASE OF SPECIAL RECORDS
YOU MUST CHECK ( ) A RESPONSE TO EACH OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH INFORMATION:

___I DO ___I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.
___I DO ___I DO NOT authorize disclosure of treatment or diagnosis of HIV or AIDS (including test results)

Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164 These rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

PURPOSE FOR USE OR DISCLOSURE: __Personal Use __Treatment __Legal __Other ________________

EXPIRATION: Unless another date, event or condition is listed below, this authorization will expire one (1) year from the date it is signed. Other date, event, or condition: ______________________

I understand North Carolina Solutions may not condition treatment or eligibility for care on my providing this authorization except if such care is (1)research related, or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. If Client refuses to provide authorization under the aforementioned circumstances, North Carolina Solutions may refuse to provide care or treatment for these purposes.
I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and Client has the right to revoke this authorization at any time in writing and upon delivery to *North Carolina Solutions* except to the extent that action has been taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

____ Date: ________________
Client's Signature

____ Date: ________________
Signature of __*Parent/Legal Guardian* __If other, specify relationship: ______________

Witness Signature: ______________________________ Date: ______________

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

Client Name: ______________________ Date of Birth. ______________

FROM (PERSON/AGENCY): *NC SOLUTIONS*
TO (PERSON/AGENCY) School

FROM (PERSON/AGENCY) School
TO (PERSON/AGENCY) *NC SOLUTIONS*

INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):

___Admission/ Evaluation /CCA ___Medications ___Medical/Physical History
___Discharge Summary ___Labs ___ History/Psychosocial
___Staff Notes ___Treatment Progress ___Testing
___Other: ______________________________

RELEASE OF SPECIAL RECORDS
YOU MUST CHECK ( ) A RESPONSE TO EACH OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH INFORMATION:
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______________________________ Date: ______________
Client's Signature

______________________________ Date: ______________
Signature of __*Parent/Legal Guardian* __If other, specify relationship ______________

Witness Signature: ______________________________ Date: ______________

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

Client Name: ______________________________ Date of Birth: ___________________

FROM (PERSON/AGENCY): *NC SOLUTIONS*
TO (PERSON/AGENCY) Primary Care Physician

FROM (PERSON/AGENCY) Primary Care Physician
TO (PERSON/AGENCY) *NC SOLUTIONS*

INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):

___Admission/ Evaluation /CCA ___Medications ___Medical/Physical History
___Discharge Summary ___Labs ___ History/Psychosocial
___Staff Notes ___Treatment Progress ___Testing
___Other: ____

RELEASE OF SPECIAL RECORDS

YOU MUST CHECK ( ) A RESPONSE TO EACH OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH INFORMATION:

___I DO ___I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.
___I DO ___I DO NOT authorize disclosure of treatment or diagnosis of HIV or AIDS (including test results)

Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law

PURPOSE FOR USE OR DISCLOSURE: __Personal Use __Treatment __Legal __Other ________________

EXPIRATION: Unless another date, event or condition is listed below, this authorization will expire one (1) year from the date it is signed. Other date, event, or condition: ________________________

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I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and Client has the right to revoke this authorization at any time in writing and upon delivery to *North Carolina Solutions* except to the extent that action has been taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

____ Date: ___________________
Client's Signature

____ Date: ___________________
Signature of __*Parent/Legal Guardian* __If other, specify relationship: ______________

Witness Signature: ______________________________________ Date ________________

nc north carolina solutions

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

Client Name: ________________________ Date of Birth: ________________

__FROM (PERSON/AGENCY)
__NC SOLUTIONS______

__TO (PERSON/AGENCY)
Trillium Health Resources________

__ FROM (PERSON/AGENCY)
Trillium Health Resources______

__TO (PERSON/AGENCY)
____NC SOLUTIONS______

INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):

___Admission/ Evaluation /CCA ___Medications ___Medical/Physical History
___Discharge Summary ___Labs ___History/Psychosocial
___Staff Notes ___Treatment Progress ___Testing
___Other: ______________________________________

RELEASE OF SPECIAL RECORDS

YOU MUST CHECK ( ) A RESPONSE TO EACH OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH INFORMATION·

___I DO ___I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.
___I DO ___I DO NOT authorize disclosure of treatment or diagnosis of HIV or AIDS (including test results)

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PURPOSE FOR USE OR DISCLOSURE: __Personal Use __Treatment __Legal __Other ______________

EXPIRATION: Unless another date, event or condition is listed below, this authorization will expire one (1) year from the date it is signed. Other date, event, or condition: ____________________

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I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) and the Privacy Act of 1974 (5 USC552a) and Client has the right to revoke this authorization at any time in writing and upon delivery to *North Carolina Solutions* except to the extent that action has been taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

______________________________________ Date: ______________
Client's Signature

______________________________________ Date: ______________
Signature of __*Parent/Legal Guardian* __ *If other, specify relationship:* ____________

Witness Signature: ____________________________ Date: ______________

I have read and received a copy of the NC Solutions policy regarding missed appointments and non-adherence to my treatment plan. I understand I can access my treatment plan upon request. I understand that missing scheduled appointments can interfere with my progress toward my treatment goals. As a result, I am aware that missed appointments may lead to the cancelation of future appointments. I am aware that questions regarding this policy can be discussed with my NC Solutions staff. I am aware that I may refuse treatment without consequence.

Signature_______________________________ Date____________________

Witness_________________________________ Date____________________

RIVERVALLEY CONSULTING SERVICES, INC.
AND AFFILIATED CORPORATIONS ("RiverValley")

INFORMED CONSENT FOR TELEHEALTH SERVICES

Patient's Name:__________________________ Date of birth:____________________

Telehealth means the use of a two way interactive video to permit a real-time service to take place between a patient at one location and a medical specialist at another distant location. Telehealth may be utilized for diagnosis, consultation, treatment, transfer of medical data, or medical education.

1. I understand RiverValley has requested me to engage in a telehealth service with ____ ("medical specialist.")

2. RiverValley has explained to me how two-way interactive video conferencing ("video conferencing") technology will be used to provide the telehealth service. I understand this service will not be the same as a direct patient/ provider visit due to the fact that I will not be in the same room as the medical specialist.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my RiverValley provider or I can discontinue the telehealth service if it is felt that the video conferencing connections are not adequate for the situation.

4. I understand my medical and/or mental health information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the teleheath service other than my RiverValley provider and medical specialist in order to operate the video conferencing equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand I will be informed of their presence before the telehealth service and will have the right to request the following: (1) omit specific details of my medical/mental health history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth service at any time without affecting my right to future care or treatment.

5. I understand I have the right to inspect all information obtained and recorded in the course of a telehealth service, and may receive copies of this information upon my request.

6. I understand the laws that protect privacy and confidentiality of medical information also apply to telehealth, and no information obtained in the use of telehealth which identifies me will be disclosed without my consent unless required by law.

7. I have had the alternatives to a telehealth service explained to me, and in choosing to participate in a telehealth service, I understand that some parts of the service involving physicial tests may be conducted by individuals at my location at the direction of the medical specialist at the distant location.

8. I have read this document carefully, and understand the risks and benefits of the telehealth service and have had my questions regarding the process explained. I hereby consent to participate in the telehealth service(s) requested.

______________________________________ ____________________
Patient's/Parent's/Legal Representative's Signature Date

RIVERVALLEY CONSULTING SERVICES
NORTH CAROLINA SOLUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that RiverValley Consulting Services, Inc., and it affiliates including NORTH CAROLINA SOLUTIONS is part of an organized healthcare arrangement and that these providers may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information I used and shared. I understand the organized healthcare arrangement has the right to change this notice at any time. I further understand if I have any questions in the future, I have the right to have them answered by contacting NORTH CAROLINA SOLUTIONS or by visiting the site at www.rvbh.com.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

PRINT CLIENT FULL NAME

CLIENT SS#/ or MR#

CLIENT SIGNATURE

DATE

CLIENT LEGAL REPRESENTATIVE (if applicable)

DATE

PRINT NAME OF LEGAL REPRESENTATIVE

RELATIONSHIP TO CLIENT

WITNESS NAME (PRINT)/LOCATION COST CENTER

FOR PROVIDER USE ONLY:
RiverValley Consulting Services and its affiliates including NORTH CAROLINA SOLUTIONS have made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the HIPAA Notice of Privacy Practices:
(Identify the efforts that were made to obtain the individual's written acknowledgment, including the reasons (if known) why acknowledgement was not obtained.)

North Carolina Solutions Authorization for Treatment and Notice of Financial Responsibility

Client Name______________________ **Date of Birth**________________________

Permission for Treatment:

I hereby authorize the staff of North Carolina Solutions to render treatment and/or services to·

____*whose relationship to me is (check one).*

_______Self _______Child _______Spouse _______Other (specify) ____________________

Patient Rights: I hereby acknowledge that my Rights and Responsibilities as a Patient/Client of River Valley Behavioral Health have been explained to me and that I have been given a written explanation of these rights and responsibilities.

Right to Choose a Provider: I acknowledge that I have been given the opportunity to select the provider(s) of my choice I am aware that I can change provider(s) at any time should I become dissatisfied with my services

Consent for Emergency Medical Services: In the event that I or the individual in my custody need emergency medical care while engaged in services at North Carolina Solutions I give permission for NC Solutions Staff to· 1) Administer emergency medical care, 2) Contact family members to inform them of the emergency; 3) contact my or the individual in my custody's physician

Notification of Follow Up: Representative of North Carolina Solutions may contact you during the course of treatment and or following discharge from treatment to determine your satisfaction with the service received at this agency.

Assignment of Benefits: I authorize North Carolina Solutions to bill my third party payment source for billable services received and for any payable benefit to be paid directly to North Caronia Solutions. Third party payment sources include but are not limited to Medicare, Medicaid, commercial insurance, and self-insured insurance plans. My signature or photocopy of my signature shall be valid for an indefinite period while service are being received unless specifically revoked by me in writing

Authorization for Release of Information to Third Party Payer Sources: I authorize River Valley Behavioral Health to furnish all third party payment sources which are being billed for service provided to me with information necessary for that third party payments sources to verify payable benefits, to process claims and to process any payable benefits. My signature or a photo copy of my signature shall be valid for processing claims and payable benefited for an indefinite period while services are being received unless specifically revoked by me

Payment Agreement: I understand that I am responsible for the charges for the services which I receive. If I am covered by Medicare I will be responsible for any deductible, co-insurance, or services not covered by Medicare and billable to the Medicare recipient. If I am covered by Medicaid, I will be responsible for any continuing income amount, spend down or service not covered by Medicare, Medicaid determines what these amounts are If I am covered by Champus, commercial insurance or a self-insurance insurance plan, I will be responsible for any amount not covered by my payment source such as but not limited to deductible and co insurances I am not responsible for any amount that represents a contractual agreement between NC Solutions and my third party payment source Reduced fees are available based on a family size and income. Please ask a Customer Service Representative if you think you may be qualify for reduced fees

All charges which I am legally responsible for are due and payable in full upon recipient of services. A demand for payment shall be considered as accomplished upon presentation of a billing or a verbal or written request for payment Failure to make payment may result in NC Solutions initiating any necessary collection action as provided in State and Federal collection laws

______________________________ ____

Client Signature Date Responsible Party Signature Date

____

Witnessed Date

Permission to Video Record for Training Purposes

Dear Parents/Guardians:

We are committed to providing quality training, to our staff to insure the highest quality treatment for your child. Our new training program will be using video recording techniques. The recordings will only be viewed by NC Solutions staff for the purpose of training. All recordings will be kept confidential. The recording will help:

- Provide feedback to staff to improve their performance
- Formally assess staff implementation of treatment plans
- Evaluate accuracy of data recording
- Evaluate and improve our training and assessment processes

This is a request for permission to allow your child to be recorded in the clinic setting for training purposes. Please check and fill out the information below that applies and return.

☐ I, ______________________________(print your first and last name) hereby authorize video recording of my child ___________________________(print child's first and last name) for the purpose of staff training and evaluation. I understand that video recordings will be used for training and evaluation purposes only.

- Any other use of the recordings will require specific written permission. _____Initials

☐ I, ____________________________ (print your first and last name) do not give permission for __________________________ (print your child's first and last name) to be video recorded for staff training purposes.

____
Signature of Parent/Guardian Date

EXPIRATION: Unless another date, event or condition is listed below, this authorization will expire one (1) year from the date it is signed. Other date, event, or condition: __________________________

I understand North Carolina Solutions may not condition treatment or eligibility for care on my providing this authorization except if such care is (1)research related, or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party If Client refuses to provide authorization under the aforementioned circumstances North Carolina Solutions may refuse to provide care or treatment for these purposes

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and Client has the right to revoke this authorization at any time in writing and upon delivery to *North Carolina Solutions* except to the extent that action has been taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form

3904 Oleander Dr. #102 Wilmington, NC 28403 | 910-313-3232

nc north carolina solutions

Authorization to pick up a child from *NC Solutions*

Name of Child: ______________________________

I hereby inform NC Solutions that the people listed below are authorized to pick up the above named child. Accordingly, NC Solutions is hereby instructed to release my child into the care of the following people.

AUTHORIZED PICK-UP PERSON:

	Name	*Relationship to Child*	*Phone Number*
1.			
2.			
3.			

I understand that:

- *Parents/guardians must inform NC Solutions of the name of the person who is picking up their child on any day they themselves are not.*
- *The "Authorized Pick-Up Person" must be at least 18 years old and may be asked to provide a photo ID to the staff.*
- *This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.*

______________________________ ______________

Parent/Guardian Signature *Date*

____

Witnessed by NC Solutions Staff

nc north carolina solutions

February 10, 2020

To our parents and caretakers:

We are now providing an assortment of edible reinforcers to assist in the reinforcement and motivation of our clients as part of their therapy. These are small pieces of food—for example, Skittles, popcorn, marshmallows, etc. and are given in small amounts throughout their session/s. Please note that this list is only an example.

We are aware of our clients' specific dietary restrictions, so we will only use edibles that do not violate these restrictions.

If your child's dietary restrictions have changed, or if you have any questions or concerns about the use of edible reinforcers, please contact, Clinic Coordinator, Kristin Nelson.

If you would like to bring in your own, you are welcome. Additionally, if there are specialized edibles that you think we may not have but want us to buy, you are also welcome to let us know.

Thank you

I am aware of these changes and will note any restrictions below.

____
Signature

____

February 19, 2019

Dear parents/guardians;

On occasion, different snack or food items are brought into our office for staff or clients. For example, if someone is celebrating a birthday, they may bring in cupcakes to celebrate with their friends.

If your child expresses interest in these items, we would like permission to give them some of those items (in moderation). We are aware of client's specific allergies and would take that into close consideration.

I ______________________ give permission for ________________ to have these items when the situation arises.

I ______________________ DO NOT give permission for ______________ to have these items when the situation arises.

Thank you for your attention to this matter ☺